Provider Appeal and Reconsideration Form

MCNA Dental · Louisiana EPSDT and Adult Denture Programs



This form is not to be used for initial claim submission or claims adjustments (such as corrected claims). Complete and submit this form to MCNA including all documents that support your request. Appeal request must be filed within 90 days from the initial claim determination and a reconsideration request must be filed within 365 days from the date of service on the claim.

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If you are submitting a BULK APPEAL, please submit a spreadsheet that includes the Member Names, Claim Numbers, Denial Reasons, and Dates of Service for each claim. Please also specify the reason(s) for the appeals.

Provider Information			
Lost Name First Name	Data (MM/DD/VVVV)		
Last Name, First Name	Date (MM/DD/YYYY)		
Provider ID Number	er ID Number Provider NPI Number		
Telephone Number	Street Address		
Contact Name	City	State ZIP	
Member Information			
Last Name, First Name	Claim Number(s)		
Date of Birth (MM/DD/YYYY)	Date of Service (MM/DD/YYY	YY)	
MCNA Member ID Number			
MCNA Member 1D Number			
Appeal Reason	Supporting Document	ation	
Below are reasons you can appeal a claim that has been denied. You may attach a detailed explanation for this appeal.	Please check all that apply.		
☐ Untimely Filing	☐ Chart Notes, Narratives,	Models, Radiographs	
☐ Non-Covered Benefits	☐ Proof of Original Submis		
☐ Medical Necessity	□ Copy of Remittance Adv	ice (RA)	
☐ Other Reason(s)	□ Other Documentation		
Signature	Date		
Mail Or Fax Completed Form To:	For Que	estions Contact:	

Mail Or Fax Completed Form 10:

MCNA Dental, Attn: Provider Appeals

200 West Cypress Creek Road, Suite 500, Fort Lauderdale, Florida 33309

Fax: 954-628-3330

Do not fax requests that include x-rays or an ADA claim form. Please submit via mail.

1-855-701-MCNA (1-855-701-6262) Monday - Friday, 7 a.m. - 7 p.m. CST